STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155561	A. BUILDING _____ B. WING _____	C 08/05/2011

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GOOD SAMARITAN HOME & REHABILITATIVE CENTER	231 N JACKSON ST OAKLAND CITY, IN 47660

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F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00093087. This visit resulted in a partially extended survey - immediate jeopardy.

This visit was in conjunction with the Post Survey Revisit to the Investigation of Complaint IN00091180 completed on 6/23/11.

Complaint IN00093087 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.

Survey dates: August 4 and 5, 2011

Facility number: 000327
Provider number: 155561
AIM number: 100273920

Survey team: Jennie Bartelt, RN

Census bed type:
SNF/NF: 81
Total: 81

Census payor type:
Medicare: 9
Medicaid: 49
Other: 23
Total: 81

Sample: 5
Supplemental sample: 11

These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.

Quality review 8/12/11 by Suzanne Williams, RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident at risk for elopement was supervised to prevent elopement. The deficient practice affected 1 of 3 residents reviewed for elopement risk and the use of Wanderguard alarms in a sample of 5. (Resident G) The deficient practice had the potential to affect 15 other residents using Wanderguards among the 81 residents residing at the facility. (Residents E, I, J, K, L, M, N, O, P, Q, R, S, T, U, and V) Resident G eloped from the facility when a visitor held the door open for her. The Wanderguard alarm sounded, and staff failed to ensure no resident had eloped from the building. Resident G wandered away from the building and was picked up in an automobile by an unidentified passerby. The passerby took Resident G to the local police, who returned her to the facility. The immediate jeopardy began on 7/1/11 when Resident G eloped from the facility. The Administrator, Assistant Director of Nursing Services, Staff Development Coordinator, and Memory Care Director were notified of the	F 323	Past noncompliance: no plan of correction required.	

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F 323	Continued From page 2	F 323		

immediate jeopardy at 6:00 p.m. on 8/5/11. The immediate jeopardy was removed 7/2/2011 with the placement of the resident in the secured unit of the facility and staff monitoring of doors pending repairs by the security company. The deficient practice was corrected as of 7/27/2011 after two visits by the security company confirmed the alarms had been adjusted to the appropriate sensitivity and all staff had been inserviced on the importance of responding to alarms, the actions to be taken when responding to alarms, and the consequences for not responding to alarms.

Findings include:

During interview at the Entrance Conference on 8/4/11 at 2:00 p.m., the Administrator indicated she had expected an investigation into her report of a resident's elopement from the facility, which she had sent to the Indiana State Department of Health. Documentation related to the facility's report was requested.

During the Initial Tour completed on 8/4/11 at 2:45 p.m., the Staff Development Coordinator (SDC) indicated residents assessed as "exit seekers" are provided a Wanderguard Code Alert bracelet that is worn on the wrist or ankle. The SDC also indicated the facility's secured unit has a locking system that requires a code for opening the secured unit doors into the remainder of the facility, but these doors are not related to the Wanderguard Code Alert system. The SDC indicated if a resident wearing a Wanderguard Code Alert bracelet nears an exit door to the outside of the building, the door locks down, and if the resident exits the door, an alarm sounds. The SDC indicated the Maintenance Supervisor

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F 323	Continued From page 3 checks the facility's exit doors for functioning of the Wanderguard system. During interview on 8/4/11 at 3:00 p.m., the Administrator indicated on 7/1/11, a visitor opened the door and allowed Resident G, who was wearing a Wanderguard, to leave the facility. The Administrator indicated the alarm sounded, a nurse looked out the door, saw no one, and turned the alarms off. On 8/4/11 at 3:40 p.m., the Administrator provided a packet of paperwork indicating her investigation into the elopement of Resident G. Review of the paperwork indicated the following: An Incident/Investigation Report from the Oakland City Police Department, dated 7/2/11 at 10:19 Saturday, indicated, "On the 1st of July 2011, Oakland City Police Department brought back an elderly woman that had left the Good Samaritan Nursing Home without permission," and "...This affiant then spoke with [name of police officer] who was on shift at that time and he stated that he was at the [name of service station] in Oakland City when a male in his 30's drove up and stated to him that he saw an elderly female walking and she seemed confused so he asked her if she needed a ride and she said yes and asked him to take her to [name of street]. The male instead took her to the police and that is when she got into [name of police officer's] police vehicle and she told him that she wanted to go home on [name of street]. [Name of police officer] stated that when he was speaking with her she could not tell him exactly where her house was and that is when he received a dispatch from a 911 call from Good Samaritan of	F 323		

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a missing resident. [Name of police officer] stated that he then took [name of Resident G] to the Nursing Home and released her to them."

An unsigned notation, handwritten on a plain sheet of paper and dated 7/2/11, indicated, "[Name of visitor] came into facility he noticed a lady stand [sic] by front entrance & held door for her to leave facility. [Name of Resident G's spouse, also a resident at the facility] came to nurses station stated his wife & he argued & she said she was going home. Staff immediately started to look for [name of Resident G]. Staff paged her name overhead & [name of visitor] went to nurses station and informed staff he held door for a woman. Showed him picture of [name of Resident G] he concurred that it was her. Staff called 911 - police brought [name of Resident G] back to facility. Per police [name of Resident G] got a ride from a gentleman he quickly realized she was confused so he took her to police at [service station] & police brought her to facility."

Another notation, handwritten on a plain sheet of paper, undated, with the name of the visitor with the visitor's phone numbers in the lower corner of the paper indicated, "When I walked up to the door and a lady carrying her purse wearing a sweater was approaching the door I opened the door & let her out the door. She thanked me and left outside. Sometime later I noticed staff walked to [name of resident] door then I hear a page that staff was looking for someone so I then ask a nurse what the lady looked like & I realized she was the lady I opened the door [sic]. Nurse she [sic] got a picture of the lady - so we [illegible word] right away it was her."

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A type-written statement on a plain piece of paper, dated 7/5/11, indicated, "On July 1st, 2011, the date [name of resident G] eloped, I heard the alarm sound on the front door. I went to the front door to observe the interior and exterior surroundings of the entrance. I did not see anyone, so I entered the code and reset the alarm." Typed at the end of the statement was the name of LPN #9. Handwritten on the paper was "Interviewed by" followed by an illegible signature.

During interview on 8/5/11 at 3:20 p.m., the Administrator indicated, "[Name of alarm services company] redid the [alarm] system" since the facility was purchased by American Senior Communities. The Administrator indicated the alarms, especially at the ambulance and front doors, alarmed frequently, even when caught by the wind. The Administrator indicated the alarms sounded "all the time" when people came in and out the front door and staff "got conditioned." The Administrator summoned LPN #9 for interview. During interview with LPN #9 and the Administrator, LPN #9 indicated she was not the nurse responsible for Resident G on July 1 at the time of the elopement, but she was working Station 1, near the front door. LPN #9 indicated the event happened about 8:00 p.m., and she thought the resident was gone about 20 minutes. LPN #9 indicated she "went outside to look, but saw no one, and came back" into the facility. LPN #9 indicated Resident G and her husband "stayed in their room most of the time." LPN #9 indicated at the time of the elopement, the door alarms were "constantly going off."

During interview on 8/5/11 at 5:15 p.m., LPN #13

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indicated that until recently the facility's exit doors, especially the front door and ambulance doors, alarmed frequently. LPN #13 indicated when the door alarmed, an indicator light at the nurse's station indicated which door was alarming. She indicated from her unit she most frequently attended to the ambulance door. LPN #13 indicated she would check the door, reset the alarm, and often it would immediately sound again, especially if it was storming.

Review of the American Senior Communities policy for "Missing Resident/Resident Elopement," with most recent revision date of 1/06, provided on the work table on 8/5/11 at 1:00 p.m., indicated, "It is the policy of this facility that personnel who have residents under their care are responsible for knowing the location of those residents...."

Resident G's clinical record was reviewed on 8/4/11 at 4:15 p.m. The record indicated the resident was admitted to the facility on 6/21/11.

Nurse's Notes, dated 6/21/11 at 4:30 p.m., indicated, "Res [resident] was brought in the facility @ this time by nephew in auto. Res in satisfactory condition. Res restless wanting to go back home. Redirected easily. Placed wander guard to L [left] ankle...."

A Care Plan with Problem Start Date of 6/24/11, indicated, "Problem: Resident is at risk for elopement due to: resident states she wants to go home. Goal: Resident will not leave the facility unattended." Approaches included, but were not limited to, "...Electronic monitoring bracelet, check function/placement every

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shift....Observe whereabouts....Walk with resident...."

During observation of testing of the facility's exit door alarm system completed with the Maintenance Supervisor on 8/4/11 at 3:50 p.m., the facility was observed to have six exit doors connected to the Wanderguard system. Using a Wanderguard Code Alert, the Maintenance Supervisor demonstrated how he checked the doors' functioning, and all doors were functioning at the time.

On 8/5/11 at 5:10 p.m., the Administrator provided a list of all residents in the facility who were monitored using the Wanderguard Code Alert system. During interview at this time, the Administrator indicated all residents were re-assessed related to risk for elopement after Resident G eloped. The list indicated 16 residents, including Resident G, were wearing the Wanderguard bracelet to alert staff to their elopement from the facility. The residents other than Resident G were: Residents E, I, J, K, L, M, N, O, P, Q, R, S, T, U, and V.

The immediate jeopardy that began on 7/1/11 was removed on 7/2/11 after the resident was placed in the facility ' s secured unit and staff provided monitoring of the facility doors. The deficient practice was a past noncompliance that was corrected as of 7/27/11, prior to the start of this survey, with the facility ' s implementation of a systemic plan that included the following: the door alarm company serviced the doors and adjusted the sensitivity settings; the Wanderguard Code Alert Monitoring for functionality was completed daily; and all staff were inserviced regarding each

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F 323	Continued From page 8 staff member ' s responsibility to respond to alarms and conduct a search until each resident ' s location and safety was assured. These corrections were verified by review of inservice sign-in sheets and training materials; review of invoices and description of service from alarm company; interviews with staff regarding knowledge of protocol to follow when a door alarm sounds; and observations on 8/4/11 between 2:00 p.m. and 5:45 p.m. and on 8/5/11 between 1:00 p.m. and 6:15 p.m. when a resident approached the door and/or the door ' s functioning was tested. During these observations, staff responded immediately to the appropriate door and conducted a search until the location of all residents was determined. This federal tag is related to Complaint IN00093087. 3.1-45(a)(2)	F 323		